

## **Supporting the Decentralized Delivery of Health Services: USAID and the District Basket in Zambia \***

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### **Summary**

This report constitutes a modest attempt to assess the effectiveness of the sector program assistance (SPA) provided by USAID in support of health sector reforms in Zambia. SPA involves the disbursement of generalized resources following the implementation of policy or administrative reforms that are considered to be key constraints to sector progress. Beginning in fiscal year 1999, Congressional restrictions have limited USAID's ability to use Child Survival and Health (CSH) funds as SPA. The health SPA program in Zambia, which was initiated just prior to the imposition of the Congressional restrictions, is therefore the only remaining program of its kind in Africa. With the program due to expire in 2004, this report was requested to explore the rationale for extending the program.

The SPA program provides for up to \$2 million per year to be disbursed to the Government upon verified completion of actions that are thought to redress the most serious constraints to the improved health of Zambians. The impact of the SPA is expected to result mainly from the achievement of these milestones even though the local currency equivalent of the funds is jointly programmed by USAID and the Government into a basket to which seven other donors plus the Government contribute that directly supports the delivery of health services at the district level. In practice, however, the influence of the SPA is closely related to the district health basket. Milestones that involve reforms beyond the control of the most direct beneficiaries of the SPA have proven consistently difficult to meet, whereas milestones within the control of the basket beneficiaries have generally been met. The report therefore aims to assess the effectiveness of the SPA in the context of the achievements of the overall basket.

The district basket is seen by many as one of the first concrete outputs of Zambia's health Sector Wide Approach (SWAp). The SWAp grew out of a strong Government commitment in the early 1990s to decentralize health service delivery. By increasing the share of funding provided to districts and, even more importantly, improving the predictability of resource transfers, the basket made the Government's commitment to decentralization a reality. Predictable funding enhanced the ability of districts to develop credible action plans, which are now prepared on an

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\* Field work for this report was undertaken over the period 26 April– 7 May 2004, during which interviews were held with representatives of various levels of Government, several donors active in the health sector, and USAID staff and contractors. A complete list of meetings attended and persons met is included in Annex 1. Thanks are due to Barbara Hughes and Edna Mulenga of USAID/Zambia for arranging the interviews on which this report is primarily based. Valuable comments that improved the report were received from Tony Daly, Yann Derriennic, Jason Fraser, Barbara Hughes, Mary Alice Kleinjan, and Cosmas Musumali. Additional comments may be sent to [bfrantz@usaid.gov](mailto:bfrantz@usaid.gov). Views expressed herein are those of the authors and should not be attributed to USAID.

annual basis. It also provided the impetus for the development of sound financial management and monitoring systems. The result has been greater accountability for resource use and a system of health service delivery that is more responsive to citizen preferences. Owing to these various improvements, the health sector has come to be viewed as a leader in the Government-wide reform effort.

USAID's contributions to the district basket – both through the SPA and complementary investments – have been an important part of the changes witnessed in the health sector. The system of “hard” milestones used to guide SPA disbursements has helped sustain momentum for Government reforms related to the basket. The SPA has also given USAID a great deal of influence over a large share of the resources available for delivering health services in Zambia. By not contributing to the basket, the legitimacy of USAID's claim over how resources in the health sector are allocated would be much more limited. USAID complementary investments to support the development of financial management and monitoring systems, as well as technical assistance provided to build the capacity to effectively utilize them, have enhanced the effectiveness of the SPA and the basket more generally. The SPA and complementary project assistance have thus each made the other more effective.

The experience in Zambia offers ample evidence to suggest that SPA can be an effective aid instrument to support health sector reforms, and, as such, it is recommended that the restriction on the use of CSH funds as SPA be removed. In this particular case, SPA helped translate the Government's commitment to a decentralized health service delivery system into reality. More generally, SPA gives USAID a legitimate claim over how the total resource envelope in a sector is used rather than limiting its influence to that relatively smaller share of resources that is under its direct control. It is the total resource envelope whose effect will be seen in national-level indicators – normally not the effect of USAID assistance. Finally, SPA can make the project and technical assistance USAID traditionally provides more effective, and again, this was demonstrated in the case of the Zambia health SPA.

## Introduction

USAID experience with sector program assistance (SPA) in support of health reforms in Africa dates to the mid-1980s. SPA involves “the provision of generalized resources to assist host governments in achieving agreed-upon sectoral goals and objectives” (USAID 1996). For roughly ten years beginning in 1986, USAID developed health SPA agreements in seven African countries.<sup>1</sup> This period was characterized by extremely difficult economic circumstances across the continent, which provided the impetus for far-reaching reforms in a number of countries. These reforms often included efforts to alter the manner in which health services were financed, place greater emphasis on primary care services, and decentralize the planning and management of service delivery.

For a variety of reasons, SPA did not live up to expectations (Farrell 1999, Setzer and Lindner 1994, Donaldson 1994). This is not to say that the programs were failures; indeed, they did contribute to significant health policy changes in a number of countries. Rather, the expectations

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<sup>1</sup> These were Botswana, Cameroon, Ghana, Kenya, Niger, Nigeria, and Togo. However, SPA ultimately was not authorized in the cases of Cameroon and Togo.

were likely too high. Reform implementation took much longer than originally anticipated, often owing either to the absence of the necessary institutional structures or the limited capacity to follow through. In addition, the assumption that SPA would be a less labor-intensive approach to providing assistance proved to be incorrect. In fact, the opposite is true; SPA is extremely labor intensive for all involved.

The disappointing experience with SPA in the health sector meant that by the late 1990s its use had generally fallen out of favor at USAID. Within the U.S. Congress, political support for SPA as an aid instrument also waned. In fact, beginning in fiscal year 1999, the Congress restricted USAID's use of Child Survival and Health (CSH) funds as SPA. However, this restriction did not apply to preexisting SPA programs; they were "grandfathered" – i.e., allowed to run their course. In 1997, USAID initiated discussions with the Government of Zambia and began the design process for a SPA program in support of health sector reforms. Congressional approval for the program was obtained in 1998, just prior to the effective date of the restriction, and an agreement was signed with the Government in 1999. The agreement established a process whereby USAID would pool a portion of its assistance in a district health basket upon verified completion of certain reforms by the Government. This is the only remaining health SPA program in Africa.

The current Zambia health SPA agreement is due to expire in 2004. The original agreement provided for up to \$20 million to be disbursed under the program, with USAID/Zambia and USAID/Washington each providing \$10 million. By the time the agreement is due to expire, USAID/Zambia expects it will have disbursed approximately \$8 million, but funding from USAID/Washington has never materialized. With a program ceiling of \$20 million, there is thus scope for extending the agreement beyond its current expiration date. This report constitutes an attempt to explore the rationale for extending the SPA agreement on programmatic grounds.

In the context of a pooled funding arrangement, it is extremely difficult to attribute certain results to individual contributions (Norton and Bird 1998). In any case, attempting to do so would violate the spirit of such an arrangement. Canada's Auditor General, in a key statement of principle regarding the operation of the Canadian International Development Agency, has noted that "what is important is that lasting development results be achieved, not that they be attributed directly to the intervention of any particular donor" (OAG 1998: par. 53). The implication is that when ideas, influence, and, especially, resources are pooled, results should be considered collective – the outcome of a team effort in which any individual actor plays only one part (Lavergne and Alba 2003). With an increasing focus on national-level development results, this seems to be the direction in which U.S. foreign assistance programs are also evolving.<sup>2</sup>

Of course, the above does not mean individual donors cannot or should not be held accountable for their contributions. Indeed, it is possible and desirable to regularly assess the effectiveness of individual contributions to the collective results. However, the primary focus should remain the development results themselves. This combination – evaluating the overall results and the contributions of USAID to those results – is the approach we employ here to assess the rationale

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<sup>2</sup> See, for example, the description of the Millennium Challenge Account, the U.S. Government's new assistance program designed to reward good-performing, low-income countries, at [http://www.mca.gov/about\\_overview.html](http://www.mca.gov/about_overview.html), which mentions "shared development objectives" and "shared efforts" to ensure sustainability.

for extending the SPA agreement. We are concerned with two key questions. First, what have been the major achievements associated with the district health basket in Zambia? Second, were USAID's contributions to these achievements – through the SPA program and related investments – effective? Some contextual information is provided in the next section before an attempt is made to answer these questions. The final section offers some general conclusions, as well as recommendations for USAID/Zambia and USAID/Washington.

## The Context

### *The Zambian Economy and Poverty Reduction Strategy*

Once a middle-income country, Zambia has seen its living standards fall consistently since the mid-1970s. Sustained economic growth remained elusive for a variety of reasons, including the lack of economic diversification due to heavy dependence on copper, a steady decline in terms of trade, the piecemeal and uneven character of economic reforms, lack of fiscal discipline, debt overhang, high transaction and transportation costs, and a regulatory environment that still acts as a constraint to market forces. Annex 2 provides a detailed account of Zambia's macroeconomic situation. Current GDP per capita stands at approximately \$380, and 73 percent of the population is estimated to be living in poverty. Zambia is a highly aid-dependent country; in 2002, aid accounted for 18 percent of GDP and financed a large share of public expenditure.<sup>3</sup>

In recent years, economic performance has been more encouraging, reflecting the effects of economic reforms undertaken in the latter half of the 1990s. For the first time in over two decades, Zambia's economy has recorded positive growth in five consecutive years. Inflation hovers around 20 percent – still quite high but a great improvement over the levels experienced in the early 1990s, which approached 200 percent. In 2000, Zambia completed the first steps needed for the cancellation of approximately \$3.8 billion in debt under the Heavily Indebted Poor Countries (HIPC) Initiative when it reached the decision point. Obtaining debt relief is extremely important for Zambia, which is one of the most highly indebted countries in the world. It is expected to provide a boost to the Zambian economy and will free public resources for critical development programs. Achievement of the completion point – when the debt write-off becomes irrevocable – has been delayed but is expected to occur in late 2004.

To become eligible for debt cancellation under the HIPC Initiative, the Government prepared a Poverty Reduction Strategy Paper (PRSP) that covers the period 2002-2004 (MoFNP 2002). The IMF and World Bank each endorsed the PRSP in 2002, a requirement for Zambia to access additional concessional finance from both organizations. The PRSP identifies the priority policy reforms and public investments that are expected to reduce poverty over the strategy period from the current level to 65 percent, where it stood in 1996. Emphasis is placed on the agriculture sector as a key source of growth, and complementary investments in infrastructure, particularly rural roads, are given high priority. The PRSP also aims to enhance the effectiveness of service delivery in the education and health sectors. With adult prevalence rates at about 16 percent in Zambia, it appropriately places a high priority on addressing the scourge of HIV/AIDS.

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<sup>3</sup> According to Saasa and Claussen (2003), aid accounted for 55 percent of total expenditure and 85 percent of total capital expenditure.

The PRSP recognizes that all of the proposed actions must be embedded in a context of improved governance. To this end, the PRSP commits the Government to a “zero tolerance” policy toward corruption, accompanied by efforts to enhance the capacity of the Anti-Corruption Commission. It also aims to strengthen the relationship between the state and citizens through implementation of a national decentralization policy and greater transparency in the use of public resources. Reform of the civil service toward a culture of performance is expected to happen through the Public Service Reform Programme. The extent to which these wide-ranging reform efforts succeed will have a great deal of bearing on the ability of the Government to deliver on the commitments outlined in the PRSP.

### *Public Expenditure Management*

Zambia’s difficulty in maintaining fiscal discipline led to the introduction of a cash budget in 1993. Under a cash budget system, spending during a given period is supposed to be limited to revenue collected during that period. In Zambia’s case, the period is monthly. Initially, the cash budget appeared to have restrained Government spending, as suggested by the marked reduction in inflation following its introduction. But this positive result came at a price: the financing of Government operations was rendered unpredictable, and, in any case, fiscal discipline may have been illusory and certainly did not last (Dinh et al. 2002). The unpredictability of budget releases, both in terms of magnitude and timing, makes sensible planning of Government operations extremely difficult and can lead to the interruption of service delivery with potentially grave consequences.<sup>4</sup>

Unfortunately, the lack of predictability associated with the cash budget system is only one of several obstacles to translating the policy commitments contained in the PRSP into improvements in service delivery in Zambia.<sup>5</sup> In general, the link between policy, planning, and budgeting is quite weak, so budgets simply are not credible. It is normal for the budget to be approved at a level that over-commits the Government, resulting in significant divergences between actual expenditures at the end of the year and budget estimates on which annual planning is supposed to be based. The Government protects 36 percent of the domestic discretionary budget for social expenditures,<sup>6</sup> but this may overstate the commitment to adequately financing the social sectors for two reasons. First, the budget lacks comprehensiveness, as it does not cover state enterprises, pension funds, and certain other activities for which the Government must expend sizable resources. Second, real expenditure on social services actually declined over the 1990s due to the high rates of inflation.

Even if resources were appropriately allocated to priority sectors, ensuring they reach their intended beneficiaries poses a number of significant challenges. Public expenditure in most sectors is heavily skewed toward the center. However, the Government recently approved a

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<sup>4</sup> Dinh et al. (2002) cite an example in which rural health administrators were forced to interrupt inoculation programs, only to restart them later at significantly higher cost.

<sup>5</sup> The remainder of this section draws heavily on World Bank (2003, 2001).

<sup>6</sup> Domestically financed discretionary expenditure excludes foreign-funded expenditure, domestic interest payments, the allocation for arrears clearance, the civil service wage adjustments, the contingency reserve, civil service retrenchment costs, payments to the Public Service Pension Fund, net lending to Zambia Consolidated Copper Mines, and court awards made against the Government. Social expenditures are defined as current and capital expenditure on health, education, social safety nets, water and sanitation, and disaster relief.

national decentralization policy to redress this, and some sectors have already been operating in a decentralized fashion for several years (e.g., health) or have at least experimented with decentralization (e.g., education).<sup>7</sup> But decentralization still does not necessarily ensure that public expenditure is well targeted toward the poor. For example, wealthier schools tend to receive more discretionary funding than poorer schools. Thus, it is not necessarily the case that increasing expenditure in priority sectors is synonymous with assisting the poor.

Leakages in the financial system are another reason why allocating more resources to priority sectors may not be of much benefit to the poor. Expenditure controls are quite lax, and poor accounting and reporting practices make it difficult to understand exactly how funds are being spent. For example, it is widely known that “ghost workers” populate the payroll owing to the weak payroll control system, and some estimates suggest capital projects in Zambia regularly cost double what they should. These types of problems may reflect inadequate financial management capacity on the part of the Government or outright corruption. While it is difficult to disentangle the effects of each, it can probably be argued that the former creates the conditions for the latter. For the situation to improve, more effective oversight is critical. Unfortunately, audit capacity is extremely thin, and the general opacity of the budget and financial management systems limits the ability of Parliament to play its role as overseer of the executive.

In an effort to improve budget and financial management, the Government has embarked on the Public Expenditure Management and Financial Accountability (PEMFA) reform program. The PEMFA agenda includes the institution of a Medium Term Expenditure Framework (MTEF) that is expected to tighten the relationship between policy and the budget, consistent with macroeconomic targets. In addition, an Integrated Financial Management Information System (IFMIS) will be introduced to address many of the problems that result in leakages of public resources. However, it should be noted that both the MTEF and IFMIS are only tools designed to improve budget and financial management; they cannot substitute for strong commitments to maintain fiscal discipline and to enhance accountability in the use of public resources.

### The District Health Basket

#### *Evolution of the Health SWAp*<sup>8</sup>

By the early 1990s, the Zambian health care system was afflicted by, in the words of a prominent politician, “a jungle of problems:” poor infrastructure and access to services; poor conditions of service; and poor performance of most primary health care programs, all of which led to poor health indicators, such as high infant and maternal mortality rates, and a heavy disease burden (Phiri 2003). In 1991, the Movement for Multiparty Democracy (MMD) won Zambia’s first multiparty election. The MMD had developed a health policy paper that outlined a vision of “local participation and the extension of democratic values to health service development and management” (Lake et al. 2000: 39). This vision provided the basis for the National Health

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<sup>7</sup> In the education sector, however, evidence suggests that, while spending has shifted from the provincial to the district level, decentralization has not resulted in greater shares of public expenditure actually reaching schools. In fact, only between one-sixth and one-third of total funding that enters the system is estimated to eventually reach schools. The rest remains at the provincial or district level (World Bank 2003).

<sup>8</sup> A chronology of key events is provided in Annex 3.

Policies and Strategies (NHPS) document, which was approved by Cabinet in 1992. The goal of the NHPS was to provide “equity of access to cost-effective, quality health care as close to the family as possible,” a goal that remains in effect today.

Decentralization was considered the cornerstone of the reform program, with the district seen as the key Governmental management unit responsible for achieving the NHPS goal.<sup>9</sup> Autonomous district health boards (DHBs) were created to oversee district health management teams (DHMTs) charged with implementation of health service delivery. The political and executive functions of the Ministry of Health (MoH) were separated with the establishment of a legally and institutionally autonomous Central Board of Health (CBoH). MoH was stripped of its service delivery role in order to focus on policy formulation, strategic planning, budgeting, resource mobilization, and external relations. This involved a reduction in staff from 400 to 67 (Phiri 2003). CBoH became the national coordinator for health service delivery. Thus, MoH is considered the purchaser of services and contracts with CBoH, and all DHBs enter into annual service contracts with CBoH to provide services in return for monthly grants.

The reform effort led to the development of the first National Health Strategic Plan (NHSP) covering the period 1995-1998,<sup>10</sup> which provided the basis for launching the Health Sector Support Policy – now the Sector Wide Approach (SWAp) – by MoH and its Cooperating Partners (CPs), as donors are known in Zambia.<sup>11</sup> The Zambia experiment was one of the first health SWAps in Africa and therefore involved a great deal of “learning by doing” (Lake et al. 2000). While there have been periods of strained relations between the Government and CPs, often marked by slow progress or reversals of progress on reforms,<sup>12</sup> by and large the SWAp has engendered strong cooperation between the Government and CPs and among CPs involved in the SWAp. This is especially true of those CPs involved in the district health basket, who saw their influence over the health policy reform program increase significantly due to their participation in what is seen by many as one of the first concrete outputs of the SWAp.<sup>13</sup> The next sub-section examines some of the major achievements of the basket.

In 1999, MoH and a number of CPs involved in supporting the health sector signed a Memorandum of Understanding. The signatories agreed to “work within the [Government] health sector framework, as outlined in the NHSP, towards agreement on common systems for planning, reporting, disbursement, accounting, auditing and procurement (of all goods and services, including technical assistance), and evaluating the performance of the health sector

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<sup>9</sup> Zambia is currently composed of 72 districts in nine provinces.

<sup>10</sup> An interim revised plan was developed for the period 1998-2000, and a second NHSP was developed for the period 2001-2005. Preliminary work has already been undertaken as preparation for the subsequent NHSP, which will cover the period 2006-2010.

<sup>11</sup> Unusually for a SWAp, the Zambian health SWAp is based entirely on a decentralized model of service delivery. As Hutton (2003) notes, there may be both advantages and disadvantages to this approach, but it is clear that when a commitment to decentralization exists, SWAps need not have a centralizing effect as is often thought.

<sup>12</sup> This was especially true of the period 1998-2000. The period is noted for several controversial incidents, including the highly opaque contracting out of the management of Medical Stores Limited and a questionable procurement of 72 vehicles for the districts.

<sup>13</sup> The district basket was created in 1993 as a pilot activity to channel pooled assistance to three districts. Contributors to the basket at this early stage included the EC, Sweden, the UK, UNICEF, and the World Bank. In addition to the Government, current contributors include Denmark, the EC, Ireland, the Netherlands, Sweden, the UK, UNFPA, and (indirectly) USAID.

through reviews and appraisals based on jointly agreed monitoring and evaluation indicators.” Planning at the national level is thus carried out jointly, and a series of regular meetings to review progress in implementation, discuss policy issues, and scrutinize resource use are held throughout the year.<sup>14</sup> As an example of the deepening partnership between the Government and CPs, a joint mid-term review of the NHSP was undertaken (MoH 2004a), and the review team reported its findings to the Health Sector Committee, a body composed of Government, CP, and other stakeholders that convenes biannually to assess progress in implementation.

More recently, a basket fund has been established for second- and third-level hospitals.<sup>15</sup> Discussions to enable the establishment of pooled funds for drug supply, capital works, and technical assistance are also underway. This has naturally led to a proposal to expand the current district basket to these additional aspects of the health sector and, when circumstances warrant, provide the Government with sector budget support. CPs are presently engaged in a dialogue with MoH regarding benchmarks for moving toward sector budget support. Through the ongoing reform effort, the health sector thus continues to serve as a positive example for the rest of the public sector. Indeed, it is touted by the Ministry of Finance and National Planning (MoFNP) as being leader in the Government-wide reform effort. The health SWAp holds a number of lessons for other sectors and has already influenced the development of an education SWAp.

The SWAp also presents an established vehicle for new partners, such as the Global Fund to Fight AIDS, TB, and Malaria (GFATM) and President Bush’s Emergency Plan for AIDS Relief, that would like their assistance to be supportive of the ongoing health sector reform effort in Zambia. Both GFATM and the Emergency Plan involve substantial new resources; GFATM has approved close to \$122 million over two years for Zambia, and the Emergency Plan will provide Zambia with approximately \$62 million in 2004.<sup>16</sup> The scale of these two initiatives means they have the potential to significantly destabilize the public health system.<sup>17</sup> Complicating matters is the fact that these initiatives each have special reporting requirements, and the use of Emergency Plan funds is rather restricted – particularly in terms of supporting efforts to develop the health systems on which the sustained testing, treatment, and care of people under threat of HIV/AIDS necessarily depends (Behrman 2004). In general, CPs have demonstrated a strong willingness to accommodate similar special needs in exchange for sincere efforts to work in a collaborative manner in support of a common strategy.

### *Support for Decentralization*

The district health basket is housed at CBoH, and approximately \$35 million per year, including a contribution from the Government, is channeled through it. Although it comprises less than 20 percent of the resource envelope available to the health sector, the basket has provided the

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<sup>14</sup> While CPs have increasingly relied on the same sets of reports produced by the Government to measure progress in the health sector, transaction costs – at least for the central Government and CPs – have probably not been reduced, owing to the sheer number of meetings (MoH 2004a). A proposal to rationalize the frequency of and participants in the various SWAp-related meetings was therefore recently approved (MoH 2004b).

<sup>15</sup> First-level hospitals are beneficiaries of the district basket.

<sup>16</sup> The year refers to the U.S. Government’s fiscal year, which runs from 1 October 2003 – 30 September 2004.

<sup>17</sup> For example, GFATM funds doubled the budget of the Kabwe DHMT but did not provide for additional staff to manage the funds.



impetus for translating the policy of decentralization into reality.<sup>18</sup> The basket was mainly designed to cover district recurrent costs and essential program-related expenditures and, as such, gave CPs a legitimate stake in the Government's commitment to decentralize health service delivery.<sup>19</sup> As a result, the share of funding directed to the districts in total public health expenditure rose from 5.7 percent in 1991, to 40 percent in 1995, to 52 percent in 1999, and to more than 54 percent in 2002 (Phiri 2003, Lake et al. 2000).<sup>20</sup> Furthermore, because an objective formula is used to allocate resources across districts, funding is now better targeted to more disadvantaged districts.<sup>21</sup> But not only have districts seen their budgets increase; perhaps more importantly, the basket has greatly improved the predictability of funding. Districts now generally know how much they will be receiving from CBoH and when to expect it.

The improvements in resource predictability paved the way for greater accountability for resource use. With a predictable flow of resources, planning was made more meaningful. Thus, it became reasonable for CBoH to hold districts to account for what is achieved with the inputs they receive. Of course, CPs were also very interested in the effective use of basket resources, and expenditure ceilings and floors on certain budget items were agreed with the Government to ensure funds were targeted primarily to the delivery of services often utilized by the poor.<sup>22</sup> However, substantiating district performance required a great deal of information that was not previously available, owing to many of the problems that limit the effectiveness of public expenditure generally in Zambia. With support from CPs, CBoH developed the Financial and Administrative Management System (FAMS) and the Health Management Information System (HMIS), both of which are now operational in all 72 districts. FAMS provides detailed accounting information on resource use, and HMIS tracks health service delivery and impact indicators.

The information generated by HMIS has recently begun to systematically inform the development of annual action plans by the districts. The action plans review progress from the previous year and, if necessary, explain why targets may not have been met. Targets for the subsequent year are then set, and the activities expected to contribute to achievement of targets are costed. Box 1 draws on the Kabwe District 2004 Action Plan to illustrate the type of information contained in district action plans. These action plans are first approved by DHBs before being sent to provincial health offices and then CBoH for review and approval.

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<sup>18</sup> The basket provides \$3 per capita compared with a total resource envelope of \$17 per capita. The latter figure does not include private household expenditure on health, which, if counted, could raise the total envelope to nearly \$24 per capita. For a detailed analysis, see MoH (2004a).

<sup>19</sup> Specifically, the basket covers recurrent expenditures such as rent, electricity, water, telephone, and supplies, as well certain program-related expenditures, including fuel, salaries for some staff, and allowances. In addition, up to five percent of a district's grant from the basket can be used to purchase drugs if necessary.

<sup>20</sup> This was accomplished, in part, by cutting the provincial health offices out of the flow of funds. Resources for the districts flow directly from CBoH.

<sup>21</sup> Currently, CBoH allocates resources to districts on the basis of the following criteria: population; "remoteness," which is proxied by the presence or absence of a gas station and bank in the district; and disease burden. However, the allocation formula is currently undergoing revision.

<sup>22</sup> The expenditure ceilings and floors that were agreed between CPs and the Government likely helped guard against problems similar to those experienced in the education sector when it began experimenting with decentralization. However, as will be discussed, some of these expenditure controls are now seen as obstacles to achievement of better results in the health sector.

Provincial health offices also visit the districts on a quarterly basis to undertake performance audits and provide technical support if needed.

### **Box 1: Kabwe District Health Board 2004 Action Plan**

The Action Plan identifies the leading causes of morbidity in the district by total cases as: malaria; respiratory infection (non-pneumonia); diarrhea (non bloody); respiratory infection (pneumonia); skin infections; trauma; sexually transmitted infections (STIs); eye infections; intestinal worms; tuberculosis; ear, nose, and throat infections; and anemia. This information is in turn used to guide interventions.

There are ten priority areas for action in 2004. Each priority area contains one or more objectives for which targets have been set with reference to the current state of affairs. For example, in the area of malaria, the district has set an objective of reducing incidence from the current level of 536 per 1000 to 107 by June 2004. In the area of STIs, the district would like to strengthen laboratory services by increasing the number of testing centers from the current three to seven. It also aims to reduce the incidence of STIs from the current level of 28 per 1000 to 25 per 1000 by June 2004. Similar objectives and targets are identified for the areas of tuberculosis, adolescent and reproductive health, child health, environmental health, mental health, skin conditions, health promotion, and management.

For each priority area, activities that are expected to contribute to the objectives are identified and costed. Activities are sorted by the actor which has primary responsibility for ensuring they are effectively implemented. Thus, in the area of malaria, the **DHMT** will be responsible for providing technical support and supervision of health centers, identifying cheaper sources of insecticide treated nets (ITNs) for centers, conducting training for staff in malaria case management, and securing standards and indicators for monitoring malaria programs, among others. **Health centers** are responsible for procuring and promoting ITN usage; procuring anti-malaria drugs; conducting information, education, and communication campaigns on malaria prevention; and carrying out environmental manipulation (e.g., drainage clearing). **Communities** also have responsibilities identified in the Action Plan, which include training community spray men, sensitizing the broader community to signs and symptoms of malaria, and training community health workers to provide malaria treatment.

The Action Plan also reports on the results achieved during the previous year, and, if targets were not met, explains the reasons for this. For example, the Action Plan notes that the district did not meet its objective of reducing the incidence of malaria from 239 per 1000 to 234 by the end of June 2003. Malaria incidence at the end of the planning period was actually 313 per 1000, but the Action Plan states that this is likely due an unanticipated adjustment that was made to the district's population figures.

Overall, the Kabwe District 2004 Action Plan seems to provide a comprehensive picture of the activities undertaken in the district and their expected results. In addition, the detailed information on staffing and finances offers tremendous insight into the day-to-day operations of the DHMT and health centers.

The now biannual meeting of the Health Sector Committee – it was previously held quarterly but now represents two of five annual sector consultative meetings – is another vehicle for reviewing progress and exercising oversight. The Health Sector Committee approves funding for the subsequent period based on a review of the previous period's financial and programmatic performance. While it is encouraging to note that HMIS data is being used for assessing district performance, greater value for money could probably be achieved by better linking HMIS to FAMS (MoH 2004a). This may be an issue for the ongoing sector reform agenda.

All of the above contrasts with “normal” public expenditure management in Zambia, which, as previously noted, is characterized by weak linkages between policy and budget, can be highly centralized, is often unpredictable, and suffers from poor accounting and reporting. This is not to say that there is no room for improvement. Indeed, Bwacha (2002) offers a number of recommendations for enhancing the effectiveness of FAMS, and, in addition to better linking HMIS to FAMS, MoH (2004a) suggests revisiting many of the HMIS indicators for appropriateness. However, it is indisputable that the capacity for planning, managing resources, and reporting at the district level has improved significantly due to the basket and the associated systems that were developed to ensure basket resources are put to effective use. The result has been greater transparency in the allocation of resources for health service delivery, which widens the scope for communities to influence the type and quality of services they receive.

### *Outcomes and Impacts*

Whereas the system for the delivery of services has unambiguously improved since the early 1990s when the health reform program was initiated, the record of service delivery outcomes and health impacts has been more mixed. During the initial stages of reform, emphasis on institutional strengthening came at the expense of attention to service delivery performance. The reforms were almost derailed after five years of literally no improvements in outcome and impact indicators (Daly 2002). This has since been redressed, but performance has still not improved as much as was hoped.<sup>23</sup> On the more positive side, infant and under-five mortality seem to be declining, with both surpassing rather pessimistic projections, and deaths from malaria dropped from 34 per 1000 in 1999 to 23 in 2002. The Expanded Programme of Immunisation has raised its coverage to 73 percent from 58 percent in 1999 and in December 2003 received an award for the national measles campaign conducted in June 2003. The campaign was responsible for vaccinating almost five million children, reaching 96.5 percent of the targeted population and preventing almost 3,000 deaths.<sup>24</sup>

Unfortunately, other indicators have worsened or, at best, remain stagnant. For example, at 729 per 100,000, the maternal mortality rate is one of the highest in the world and represents an increase of 12 percent since 1996. The incidence of STIs has also increased. HIV prevalence among young women and the total fertility rate have only marginally declined, certainly not sufficiently to meet the targets that were set for the current NHSP. And the proportion of

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<sup>23</sup> Much of the data included in this sub-section is drawn from MoH (2004a).

<sup>24</sup> The measles campaign also included other health interventions, such as Vitamin A (distributed to 94.8 percent of the targeted population), mebendazole (distributed to 79.2 percent of the targeted population), and ITNs in five districts (distributed to 80.1 percent of the targeted population). For further information, see [www.measlesinitiative.org/zambia.asp](http://www.measlesinitiative.org/zambia.asp).

supervised deliveries, while rising, remains quite low at less than 50 percent, including those supervised by traditional birth attendants. In light of the generally fragile economic situation and adult HIV prevalence rates around 16 percent, it is perhaps not surprising that the public health system in Zambia has been, in the words of a Government official, “running fast to stand still.” Nevertheless, as pointed out by MoH (2004a), this should not be satisfactory to those who believe a strong public health care system can make a difference.

### *Expanding the Basket*

The disappointing progress on outcome and impact indicators has led to the identification of additional obstacles to their improvement. The basket and its related achievements helped alleviate many of the first-order impediments to service delivery in the health sector. Bottlenecks that have more recently been identified include poorly performing referral hospitals, inadequate drug supplies, human resource constraints, and the limited ability to finance capital expenditures at the district level, among others. In its current form, the district basket does not allow basket resources to address these bottlenecks or limits the extent to which they can be addressed as a result of the ceilings and floors that were imposed on certain budget items. CPs have therefore sought to expand the basket to include additional elements of the health sector and relax some of the budget ceilings and floors.<sup>25</sup>

The medium-term vision is to create the conditions necessary for CPs to be comfortable with providing sector budget support to MoH. Accordingly, MoH and CPs have been developing a set of benchmarks that will be used to assess the readiness of MoH to make effective use of sector budget support.<sup>26</sup> The benchmarks are grouped in six major categories – Procurement, Government Fund Releases, Auditing, Gender, Human Resources and Institutional and Organizational Development, Performance, and NHSP – and are assigned points according to their perceived importance. While the benchmarks are generally reasonable, Performance does not feature very prominently in the list. Indeed, out of a possible 92 points that would result if MoH met all of the benchmarks included in the list, Performance only accounts for six.

The obvious danger in expanding the basket is that institutions which stand to benefit from an expanded basket may not have the financial management and reporting systems in place to guarantee accountable use of funds. On the other hand, expanding the basket to include such institutions would provide the justification for extending the use of FAMS and HMIS to other elements of the health sector, which could result in a larger share of the resources available to the health sector being subjected to wider scrutiny. This is already happening with the second- and third-level hospitals that are benefiting from the newly created hospital basket. The case for expanding the basket to cover other elements of the sector, including drug supply, training and technical assistance, and capital expenditures thus appears strong.

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<sup>25</sup> Of course, improvements in health indicators will also depend on activities undertaken in other sectors – e.g., education, water, etc. On this score, there seems little reason to believe that much can be done about bottlenecks arising from these other sectors since the overall mechanisms for collaboration between key Government sectors tend to be weak. Part of the reason for this lays in the fact that the decentralized structure of the health sector complicates engagement with more centralized sectors (MoH 2004a).

<sup>26</sup> The version of the benchmarks referenced here was distributed on 11 May 2004.

Expanding the basket in such a way would certainly carry little risk when compared with incorporating the activities of MoH or moving directly to sector budget support. It is not entirely clear that MoH is committed to reforming its budget and financial management systems to provide enhanced transparency. Allowing the basket to finance activities of MoH would therefore most likely involve exposure of the basket to “normal” Government budget and financial management systems.<sup>27</sup> Arguably, the improvements that have been associated with the district health basket resulted in large measure from the fact that the basket has been insulated from these “normal” Government systems. Gradual expansion of the basket to a few key areas is therefore probably more prudent than a rapid shift toward budget support.<sup>28</sup>

### *The Challenge of Sustainability*

While the size of the district health basket has grown considerably in recent years, this has been entirely due to increased donor contributions. The Government’s contribution to the basket, both in absolute terms and as a percentage of the MoH budget, has fallen, and CPs are increasingly concerned with this trend. However, it is not entirely clear why the Government’s contribution to the basket has fallen. In the face of a declining budget and the apparent donor willingness to channel higher levels of assistance through the district basket, a smaller contribution may very well be a sensible response by MoH if it seeks to ensure that all of its essential functions are adequately funded. On the other hand, larger donor contributions to the basket may simply be freeing resources for inefficient expenditures elsewhere in the health sector. An expanded basket or a move toward sector budget support should provide greater insight into this issue.<sup>29</sup>

Of course, full financial sustainability requires actions at various levels, some of which are beyond the control of health sector policy-makers and managers. Ultimately, the economy will have to grow at a consistently high level to generate the revenue to adequately finance the large and – due to the effects of HIV/AIDS – increasing demands on the Government’s public health system. The fragile economic situation and the need to restrain expenditure to qualify for the HIPC completion point limit the resources available to address Zambia’s health challenges. Thus, it may be necessary to accept that sustainability might only be possible in the very long term. On the other hand, health sector managers have repeatedly avoided defining a Basic Health Care Package that is consistent with the existing resource envelope (MoH 2004a). As a result, prioritization suffers, and resources might be spent on low-priority interventions.<sup>30</sup> In the

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<sup>27</sup> Admittedly, the implementation of the Government-wide PEMFA reform program, which includes the institution of an MTEF and IFMIS, may signal a strengthening of “normal” Government budget and financial management systems. However, it is again worth reiterating the point made earlier that such tools are unlikely to prove effective in the absence of strong commitments to fiscal discipline and enhanced accountability in the use of public resources.

<sup>28</sup> It can probably be argued that effective support for capacity development requires that donors be willing to take slightly more risk than makes them comfortable. However, being blind to risk – e.g., if commitment to improve management and information systems is minimal or non-existent – may simply perpetuate dysfunctional systems.

<sup>29</sup> A preliminary conclusion is that the former may be more likely. In recent years, the Government has allocated more funds for drugs, hospital maintenance and debt servicing, epidemic control, and basic salary requirements (e-mail communication with Cosmas Musumali).

<sup>30</sup> For example, during the meeting of the Health Sector Committee, a number of CPs objected to the apparent priority given to radiotherapy and open-heart surgery.

absence of sufficient resources, some districts have come to rely upon revenue generated from cost sharing (MoH 2004a).<sup>31</sup> Whether this is positive or negative, however, is open to debate.<sup>32</sup>

A second aspect of sustainability involves the staying power of the systems that have been developed to support the decentralized delivery of health services. FAMS and HMIS became operational before the PEMFA reform program was even conceived. Fortunately, there appear to be only minor compatibility issues between FAMS and IFMIS, and the planning, budgeting, and reporting experience that has been acquired in the health sector in recent years means the transition to tools such as the MTEF should be smooth. Of greater concern is the national decentralization effort, which has the potential to alter the existing accountability structure and the manner in which resources flow between the center and districts. It is not clear that these consequences have been internalized by the various layers of management in the health sector. This is especially true in the cases of the provincial health offices and DHMTs, which were described as “spectators” to the national decentralization effort that is underway.

Finally, the shortage of human resources poses perhaps the most significant challenge to the sustainability of the changes that have been made to Zambia’s system for health service delivery. In spite of the marked improvements in capacity at the district level to plan and manage health programs, capacity remains the greatest constraint.<sup>33</sup> Building capacity, particularly when decentralization is a priority, takes a lot of time (Daly 2002). In the past, civil service reform efforts have been undertaken with the objective of meeting macroeconomic targets, but these efforts limited the ability of the health sector to recruit staff. Deaths from HIV/AIDS have also taken their toll, and it is not uncommon for skilled health workers to emigrate in pursuit of better opportunities (MoH 2004a). The situation underscores the need for ongoing training programs and, ultimately, a growing economy that provides opportunities for skilled workers at home.

### USAID’s Contributions to the District Health Basket

#### *The Flow of Funds*

USAID joined the district health basket on 9 March 1999, the date when the SPA agreement was signed with the Government of Zambia. The agreement provided for up to \$2 million annually to be transferred to the Government upon implementation of reforms in the health sector, known as milestones. The milestones were linked to the Government’s performance in three general areas: adequate and timely funding of essential health care services; achievement of people-level impact from broader coverage and better quality of health services; and improvement in financial reporting, accountability, and management of health sector resources. Each milestone was associated with a dollar value, both of which were negotiated and agreed with the Government.

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<sup>31</sup> As part of the decentralization effort, districts are permitted to set their own fee levels, though national exemption guidelines are supposed to apply to certain diseases, age groups, and services (Phiri 2003). However, evidence suggests that the exemption policy is ineffective in protecting the most vulnerable (MoH 2004a).

<sup>32</sup> Some argue that cost sharing enhances accountability between service providers and consumers, thereby improving the quality of service, whereas others argue that cost sharing significantly reduces utilization by the poor.

<sup>33</sup> Saasa and Claussen (2003: 46) note “that the SWAp faithful have grossly underestimated the institutional constraints of the [Government] system and the importance of the need to build, and perhaps more importantly, retain human resource capacities that are so pivotal in planning and implementation of very complex SWAp approaches to service delivery.”

Upon receipt of verification that milestones had been achieved, USAID would disburse the relevant amount of U.S. dollars – pursuant to rules governing the provision of SPA – into a bank account established by MoFNP exclusively for the receipt of SPA funds. According to the agreement, these U.S. dollars were to be used to service debt owed to the U.S. Government. MoFNP was expected to transfer the foreign exchange from the dedicated bank account to the U.S. Treasury and then provide the local currency equivalent of the foreign exchange to MoH as part of the Government’s contribution to the district health basket.<sup>34</sup> Once it could be verified that the appropriate amount of local currency was transferred to CBoH for the district health basket, USAID stopped tracking the funds.<sup>35</sup>

When Zambia reached the decision point under the HIPC Initiative in December 2000, it was granted interim debt relief. As part of the HIPC Initiative, the U.S. agreed to allow payments on debt owed to it to be suspended when countries reached the decision point.<sup>36</sup> Therefore, the Government of Zambia no longer needed to service debt owed to the U.S., making the SPA disbursement mechanism obsolete. The agreement was therefore amended, and the changes officially took effect on 3 June 2003. Rather than being used for debt service, the foreign exchange now generates local currency for the Government of Zambia through a foreign exchange auction system.<sup>37</sup> The local currency that is generated then becomes part of the Government contribution to the district basket.<sup>38</sup> As will be discussed, this change improved somewhat the predictability of the resource transfer to the basket.

Much of the rest of the agreement remained the same. Up to \$2 million per year is made available to the Government of Zambia pending verification of the achievement of milestones in the three general performance areas previously noted.<sup>39</sup> USAID transfers the U.S. dollars attached to each milestone that is met to a separate bank account held by MoFNP at the Bank of

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<sup>34</sup> In fact, 90 percent of the local currency equivalent was allocated to the district health basket. The agreement allowed for the remaining 10 percent to be deposited into a USAID-held local currency bank account to cover USAID administrative expenses. Once total disbursements under the SPA program surpass \$10 million, 95 percent of the local currency equivalent of disbursements will be allocated to the basket, with 5 percent going to the USAID-held account.

<sup>35</sup> Of course, this does not mean USAID was no longer interested in how resources from the district health basket were used. It simply means USAID was no longer able to identify exactly how the local currency equivalent of the funds it provided was used. Instead, USAID became interested in – and was able to exercise influence over – the manner in which all of the basket resources were used.

<sup>36</sup> Debt stock is forgiven once the completion point is reached. This applies to debt contracted prior to June 1999, when the Enhanced HIPC Initiative was agreed at the G-8 Summit in Cologne, Germany.

<sup>37</sup> However, a disbursement of \$500 thousand was made in March 2001 for milestones that were achieved by September/October 2000, when the original agreement was still in place. As a result of the HIPC Initiative, the debt service payment to which the March 2001 disbursement was to have been applied was relieved. Out of the \$500 thousand, all but about \$23 thousand was drawn down, but the \$23 thousand remains in the MoFNP bank account created exclusively to receive SPA funds. USAID/Zambia is seeking guidance on whether and how to recall the \$500 thousand disbursement from the Government and how it might program the remaining \$23 thousand.

<sup>38</sup> USAID’s financial contribution to the district basket is thus technically indirect. The foreign exchange provided by USAID is used to generate local currency, which becomes “host country-owned.” This host country-owned local currency is tracked to ensure that it forms part of the Government’s contribution to the basket.

<sup>39</sup> The amended agreement included some minor updates to the milestones, which are still negotiated and agreed with the Government. Annex 4 lists the milestones against which the most recent disbursements were made and their associated values.

Zambia. MoFNP then gives the order to sell the foreign exchange through the auction system, and the local currency that is generated is transferred to MoH to pass on to CBoH for deposit into the district basket. At this point, USAID stops tracking the funds. It is important to note that the flow of SPA funds from USAID to the basket involves a large number of actors, some of which serve mainly in an administrative capacity but any of which can slow the process.

### *Milestones and Policy Dialogue*

The impact of SPA is expected to result mainly from the milestones requiring implementation of reforms on the part of the recipient government rather than the finance *per se*. In this particular case, the finance is earmarked for the district basket, but certain milestones involve actions by actors that derive only minor or indirect benefits from the finance. A case in point is the milestone which mandates that 13 percent of domestically financed discretionary Government expenditure be directed to MoH. Clearly, this is a reform beyond the control of the most direct beneficiaries of the finance, DHMTs, DHBs, and CBoH. Instead, it is a reform whose achievement depends chiefly on MoFNP, which likely explains why it has proven consistently difficult to achieve (see Table A1). In contrast, milestones related to improvements in the planning process of DHBs, such as the introduction of financial management and reporting systems or setting of targets in annual action plans, have been met.

The influence of the SPA is therefore closely related to the processes that have taken place around the district basket. Of course, since eight CPs are involved in the basket, and the Government has maintained a strong commitment to making decentralization a reality since the early 1990s, it is not possible to attribute the many positive achievements related to the basket that were documented in the previous section to the SPA. However, the system of “hard” milestones that USAID employs to guide SPA disbursements is a significant difference between its contribution to the basket and the contributions of other CPs and is thus one way of assessing USAID’s value-added. Rather than using “hard” milestones, other CPs disburse their contributions on the basis of a general assessment of basket expenditure reporting and financial management. This implies that they have a great deal more flexibility in making their disbursement decisions.<sup>40</sup>

While Government officials prefer the flexibility afforded by the contributions of other CPs to the basket compared with USAID’s disbursements based on achievement of “hard” milestones, they admit that the milestones help sustain momentum for reforms. There is thus a good argument for USAID to remain involved in the district basket since other CPs are not likely to adopt a similar system of “hard” milestones. But the incentive for reform implementation provided by \$2 million per year is not very strong, as evidenced by the difficulty in achieving milestones that required reforms beyond the processes surrounding the district basket.<sup>41</sup> The fact that CPs are working with MoH to develop benchmarks for assessing progress therefore presents

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<sup>40</sup> For example, they might be able to go ahead with disbursements if extenuating circumstances resulted in weak Government performance, whereas the procedure for allowing USAID to do so is more formal, requiring a modification to milestones that is documented by an exchange of letters between USAID and the Government.

<sup>41</sup> While it might be desirable for the value of the SPA to increase, our assumption is that this is not likely. Of course, if the value of the SPA were to increase, this would likely enhance the incentive for reform implementation provided by “hard” milestones.



an excellent opportunity to enhance the incentive effect of the “hard” milestones.<sup>42</sup> If future USAID milestones can be drawn from the list of benchmarks developed by CPs and MoH, the milestones would implicitly be backed by a larger amount of resources than the \$2 million per year provided by USAID.<sup>43</sup>

Making use of the jointly agreed benchmarks would also bring USAID’s SPA program into better alignment with the evolving SWAp and the work of other CPs, thereby ensuring that USAID retains the influence it has in policy discussions with the Government. Currently, the dialogue with the Government on key health policy issues is dominated by those CPs that contribute to the district health basket. As a (indirect) contributor to the basket, USAID is intimately involved in the policy dialogue and is able to exercise a significant amount of influence over the total resource envelope available to the health sector. However, as the basket expands to include other aspects of the health sector, there is a danger that this influence might diminish if, in contrast to the contributions of other CPs, the SPA provided by USAID remains earmarked for the districts. Selecting future milestones from the agreed list of benchmarks, assuming it includes actions to address the most critical constraints to the improved health of Zambians, would ensure that USAID would not lose its influence and provide it with the legitimacy to shape the benchmarks themselves – and by implication the overall direction of the reform program – until they are fully finalized.

#### *Predictability of Resources Flows*

USAID disbursements to the district basket are predictable insofar as the milestones governing SPA releases are generally quite clear and specific.<sup>44</sup> The Government knows exactly what actions must be taken by what period of time to trigger SPA disbursements, and it knows the amount of funds it can expect to receive depending on which milestones it is able to achieve. Poor performance in one of the three policy areas – e.g., achievement of people-level impact from broader coverage and better quality of health services – may not affect disbursements tied to performance in another area – e.g., improvement in financial reporting, accountability, and management of health sector resources. USAID disbursements of SPA are therefore not “all-or-nothing.” These design features of the USAID SPA program should have made the flow of resources generally predictable, but a number of difficulties with implementation emerged that rendered USAID’s contribution to the basket quite unpredictable.

Under the original disbursement mechanism, Zambia’s cash budget system presented a significant challenge to the timely transfer of USAID’s contribution to the basket. Because USAID SPA was used to repay dollar-denominated debt, it never generated local currency. This meant that MoFNP might not have enough local currency at its disposal to deposit into the basket upon receipt of the foreign exchange. Indeed, this is exactly what happened on a couple of occasions. The updated disbursement mechanism, which involves auctioning the foreign exchange and generating local currency, has eliminated this source of the delay in moving funds

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<sup>42</sup> Other CPs would likely continue to make a general assessment of progress according to these benchmarks rather than assigning monetary values to certain benchmarks, as USAID does.

<sup>43</sup> In fact, it may very well be the case that the achievement of those SPA milestones that were met in the past was influenced in part by the implicit backing of the contributions of other CPs to the district basket.

<sup>44</sup> Of course, as mentioned in the previous sub-section, this feature of USAID’s approach limits the ability to adjust disbursements should extenuating circumstances intervene.

from MoFNP to the district basket, and the most recent resource transfer flowed much more smoothly as a result.

Other delays were encountered in transferring resources from USAID to the district basket due to the significant management burden placed on a wide range of actors that did not necessarily stand to benefit to the same extent from the finance. The most direct beneficiaries of the SPA are the DHMTs, DHBs, and CBoH. However, as has already been noted, the milestones often involve reforms to be undertaken not only by DHMTs, DHBs, and CBoH, but also by MoH and MoFNP to varying degrees. Furthermore, each of these actors plays an administrative role in the flow of funds. For example, MoH is responsible for compiling the documentation needed to verify the implementation of reforms, and MoFNP is responsible for transmitting the documentation to USAID. Since there is no agreed schedule for providing documentation to USAID, and \$2 million has proved to be an insufficient incentive to galvanize action by the more indirect beneficiaries of the finance, USAID's contribution to the basket remains somewhat unpredictable in spite of certain simplifications introduced by the new disbursement mechanism.<sup>45</sup>

The unpredictability of USAID's contribution to the district basket stands in stark contrast to the contributions of most other CPs. In fact, it can be argued that the predictability of most CPs' disbursements to the basket has been the driving force for many of the improvements in planning witnessed at the district level since the Government's contribution to the basket is also rather irregular owing to the cash budget system. However, this predictability has been achieved mainly by bypassing MoFNP; most CPs provide their funding directly to CBoH. The procedure used by USAID, on the other hand, ensures that the Government's budget-setting authority is fully aware of USAID's contribution to the basket and can therefore account for it when carrying out its planning and budgeting functions. USAID's approach is therefore more consistent with the Government's long-term efforts to reform its entire financial management system. Thus, the challenge for USAID is to improve the predictability of its contribution to the basket while continuing to utilize the Government's full financial management system.

### *Complementary Investments*

It is certainly the case that the district health basket provided the impetus for the development of financial management and monitoring systems such as FAMS and HMIS. Without the basket, and the predictable funding for districts it made possible, these systems would have had minimal utility. However, the systems themselves, and much of the capacity that was built to utilize them for more effective planning, were developed primarily through the support of project-type aid, much of which was provided by USAID. It is questionable whether the same could have been accomplished as quickly and effectively in the absence of the technical assistance and training provided by non-basket funds. In this case, then, project assistance complemented the funds provided through the district basket and, as a result, both were made more effective. The district basket ensured that the systems and capacity that were built through project assistance would be utilized and further developed while the project assistance helped ensure the funds provided through the district basket would be used effectively.

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<sup>45</sup> The new mechanism requires fewer administrative actions on the part of MoFNP, which no longer has to document debt service payments.

In many countries, people are not empowered to hold their governments and service providers accountable if they receive poor quality health services. Addressing the “demand side” of service delivery therefore becomes critical for delivering better outcomes (Pritchett and Woolcock 2004). Kaufmann (2003) urges greater attention to parliamentary, NGO, and citizen oversight, as well as media development, activities that are not likely to be best supported with relatively un-earmarked forms of assistance – such as baskets or budget support – provided to governments. In Zambia, the commitment to decentralization, made real through the basket, has gone a long way toward enhancing the responsiveness of health service delivery to citizen preferences. However, decentralization has been accompanied by efforts to mobilize communities to more effectively exercise their voices, and a number of these efforts, while part of the SWAp, are funded outside of the basket. USAID in particular has played a crucial role in community mobilization through some of the projects it supports. Even so, citizen influence over service delivery remains quite weak (RNE 2004), which suggests additional investments of this type may be warranted.

## Conclusions and Recommendations

### *General Conclusions*

**It is extremely important to understand how the various national reform efforts that are underway – decentralization, public financial management reform, civil service reform, etc. – are likely to affect the future of the health sector.** The national decentralization plan in particular may have some significant repercussions for the health sector, and it is not clear that these consequences have been internalized by the various layers of management in the health sector. However, these reform processes should not be seen as threats to the systems that have already been established in the health sector; rather, they should be seen as opportunities. Because the health sector has already undertaken a number of reforms itself and, in many ways, is well ahead of the wider Government, it is in a position to shape the national reform efforts on the basis of its experience. For this to happen, improving communication with the wider Government, especially MoFNP, will be important. In addition, communicating the implications of national reforms to provinces and districts will be important to elicit input from lower levels of Government that can in turn be used to inform debate at the central level.

**In light of the significant achievements of the district health basket, and some of the remaining obstacles to improvements in service delivery and health indicators, it seems to be an appropriate time to relax some of the ceilings and floors that have been imposed on the use of basket funds and consider an expansion of the basket to cover additional aspects of the health sector.** Many of the bottlenecks to improving service delivery at the district level have been relieved as a result of the basket itself and the improvements in health systems and capacity that were motivated by the basket. The current bottlenecks that have been identified include referral hospitals, drug supplies, human resources, and capital expenditures, among others. It thus makes sense to expand the basket such that it is able to address most of these issues. However, a number of interviewees urged caution in expanding the basket to cover the activities of MoH and moving toward sector budget support. It can be argued that many of the achievements associated with the district basket were due to the fact that the basket has been

very much insulated from the “normal” Government systems under which MoH operates. Because the systems used by MoH do not provide the same level of accountability as those developed to support the district health basket, a number of improvements will be needed before CPs feel the same level of comfort with an expanded basket that includes MoH or the provision of sector budget support.

**The benchmarks that have been jointly developed by CPs and MoH as part of the move toward sector budget support are generally reasonable, but some adjustments to better account for performance would strengthen them.** The previous point is not intended to imply that a move toward sector budget support is not desirable. In fact, such a move is desirable if the funds can be used effectively. In this regard, the benchmarks that are being jointly developed by CPs and MoH are extremely useful. However, performance – whether service delivery and impact targets are being met – does not feature prominently in the list. Indeed, out of a possible 92 points that would result if MoH met all of the benchmarks included in the list, performance only accounts for six. While the list of benchmarks should remain manageable, CPs and MoH may wish to consider adding a number of specific service delivery and impact targets.

**Other partners should make use of the established district basket if they are interested in supporting health service delivery through the Government.** The district basket is well established, and a great deal of systems development and capacity building has taken place to ensure that funds provided through the district basket are closely monitored and used effectively. In fact, the district basket probably provides the highest level of accountability for the use of resources in all of Government. While the financial management and reporting systems that are used to demonstrate the use and effectiveness of basket resources could still be improved, it is not entirely clear that the alternatives available to CPs interested in working through the Government – and even many of the alternatives available to CPs outside of Government – provide as much accountability for resource use while supporting local capacity development in a similar way. Further, the district basket has served to advance collaboration among CPs and between CPs and the Government. All of those involved have demonstrated a willingness to account for the special needs of certain CPs in exchange for sincere efforts to provide coordinated assistance in support of a common strategy. Thus, not only would it be desirable for new partners such as GFATM to channel at least that portion of funds destined for the Government’s use through the basket to ensure proper coordination with other CPs. More importantly, the alternatives available to such partners for ensuring the effective use of resources are rather limited. The same argument applies to the funds that will be provided through President Bush’s Emergency Plan for AIDS Relief.

**Investments that complement basket funds or budget support – technical assistance, various “demand-side” activities, capacity building for the private sector, etc. – play an extremely important role in improving service delivery and should be recognized accordingly.** It is doubtful that many of the systems that were developed and the capacity that was built in support of the district basket could have been accomplished as quickly and effectively in the absence of the technical assistance and training provided with the support of non-basket funds. While basket funds provided the impetus for systems such as FAMS and HMIS, they were actually developed through more traditional, project-type aid. In addition, in many countries, people are not empowered to hold their governments and service providers

accountable for the poor quality of services they receive, and this is seen as a key reason for the lack of quality services. The decentralization that has taken place in the health sector in Zambia apparently has gone a long way toward enhancing the responsiveness of health service delivery to citizen preferences. However, decentralization has been accompanied by efforts to mobilize communities to exercise their voices, and a number of these efforts, while part of the reform program in the health sector, are funded outside of the basket. Further, citizen influence over service delivery remains undesirably low, suggesting additional investments to redress this may be warranted. One way of doing so might be to strengthen the capacity of civil society to hold Government accountable and that of the private sector to provide high-quality alternatives to Government services. Certainly, it would make sense to be more inclusive of civil society and the private sector in the SWAp process.

#### *Recommendations for USAID/Zambia*

**The significant achievements of the district basket and the influence USAID is able to exercise over a large amount of funds to be utilized for health service delivery by contributing to the basket suggest USAID should remain part of the basket irrespective of whether it continues as a district basket or expands to cover other aspects of the health sector.** There is little doubt that the district basket has played an instrumental role in supporting many of the policy reforms that have taken place since the early 1990s in the health sector. These reforms have laid the foundation for improved health service delivery in Zambia and serve as a positive example for other sectors and even some national reform efforts that are currently underway. It is therefore to USAID's advantage to continue supporting this generally encouraging process. More significant than its financial contribution to the basket, however, is the influence USAID is able to exercise over a large share of the resources available for delivering health services in Zambia. It is the totality of resources that can be marshaled in support of the health sector which will ultimately have the effect of improving the health status of Zambians – not the comparatively lesser sum USAID brings to the table on its own, even as the largest CP in the sector. USAID's greater technical expertise when compared with other CPs and the Government means it can have a great deal of influence over the manner in which these resources are used, but this influence will be much more effective if USAID continues to contribute to the basket itself. By not contributing to the basket, the legitimacy of USAID's claim over how resources in the health sector are allocated would be much more limited.

**There are certain advantages related to the system of “hard” milestones that trigger SPA disbursements, but in the future USAID should consider selecting milestones from those agreed by CPs and MoH and thus should remain closely involved in their further refinement.** Whereas most CPs seem to disburse their contributions to the basket on the basis of a general assessment of basket expenditure reporting and financial management, USAID has always disbursed its SPA upon receipt of evidence that specific milestones have been achieved. This situation is unlikely to change if the district basket expands to include other aspects of the health sector. In an effort to harmonize the factors that are considered when deciding whether to disburse into the basket, CPs and MoH have jointly developed a list of benchmarks that, when finalized, will serve as the basis from which joint assessments of progress are made. As has been mentioned, most of these benchmarks are quite reasonable, though they could be improved with some minor modifications. While USAID should not – in any event, it cannot – soften its

approach to the milestones, it should draw from the list of benchmarks agreed by CPs and MoH to the greatest extent possible when selecting future milestones. In this way, USAID's approach would be consistent with that of the other CPs while at the same time preserving the incentive effect the "hard" milestones arguably provide to motivate the Government's reform efforts. Selecting milestones from the agreed list of benchmarks would likely enhance this incentive effect since they would implicitly be backed by a larger amount of resources than the \$2 million per year USAID provides to the basket. Of course, this suggests it is important that USAID remain involved in the further refinement of the benchmarks. In particular, it could advocate for greater emphasis on performance.

**While USAID should continue to utilize the full Government financial system with its contribution to the basket, it should endeavor to minimize the actions – both administrative and policy – required of those actors that do not benefit directly from the finance.** Unlike most donors that contribute to the district basket, USAID utilizes the entire Government financial system when it disburses its SPA. Therefore, USAID's contribution to the district basket is more consistent with the long-term reform of the Government's financial management system as it does not provide CBoH with access to extra-budgetary finance. However, the fact that there are a number of actors involved in ensuring that an amount equivalent to the SPA arrives in the district basket, some of which do not derive much benefit from the finance, can be problematic. Experience shows that such actors tend to lack the motivation to undertake actions needed to get the funds to their intended destination. This suggests that USAID should endeavor to, first, minimize to the greatest extent possible the administrative requirements placed on actors that are key to moving the funds but do not derive a benefit from the finance or whose benefit is rather indirect – especially MoFNP. This may have already been largely achieved with the most recent revisions to the SPA agreement. Second, and more importantly, USAID should select milestones against which it disburses funds that are generally within the control of the actors that derive the most direct benefits from access to the finance.

**USAID should consider ways in which its SPA disbursements can be made more predictable, perhaps by setting mutually agreed dates for document submission with the Government.** One of the most widely recognized achievements of the district health basket in Zambia is that it improved the predictability of resource transfers from CBoH to districts. This in turn enhanced the ability of districts to develop credible action plans. The improved predictability of resource transfers also provided the impetus for the development of the financial management and monitoring systems that have been put in place. Without predictable funding, developing these systems would have been of little use. Unfortunately, USAID was not able to play a part in improving the predictability of funding to the districts. There were significant problems experienced in moving funds even when the Government met milestones that were supposed to trigger disbursements due to delays in receiving documentation from the Government. There are likely to be fewer problems since the SPA agreement was revised, and the disbursement mechanism was simplified. However, there remains a great deal of unpredictability in the manner in which the SPA is disbursed owing to the fact that there is no fixed schedule for document submission providing evidence of milestone achievement by the Government. USAID might therefore consider setting mutually agreed dates for document submission with the Government. Submissions could be due one or two times per year, possibly coinciding with the biannual meetings of the Health Sector Committee.

*Recommendations for USAID/Washington*

**USAID should work with the Congress to remove the restriction on the use of CSH funds as SPA.** The experience in Zambia suggests SPA can be an effective tool for supporting health sector reforms, and USAID Missions should be given the flexibility to decide whether it might be an appropriate instrument in light of the prevailing circumstances in the countries in which they work. SPA has the potential to provide USAID with a great deal of influence over larger amounts of resources. Ultimately, it is the totality of resources that can be marshaled in support of the health sector that will be reflected in improvements in national health indicators. USAID assistance, whether in the form of SPA or project-type support, can only contribute in a very small way and is unlikely to significantly affect national indicators by itself. However, whereas project assistance does not necessarily provide USAID with a legitimate claim over the manner in which the broader health sector resource envelope is used in a given country, a contribution in the form of SPA often does. Further, SPA can serve to enhance the effectiveness of USAID investments that take the form of project support or technical assistance, as demonstrated in the case of Zambia. For all of these reasons, the prohibition on the use of CSH funds as SPA should be lifted.

**USAID should support coordination of GFATM with existing in-country processes and should advocate for the use of funds provided through President Bush's Emergency Plan for AIDS Relief in support of health systems development in focus countries.** It is clear that some of the large multilateral and bilateral initiatives in the health sector have the potential to wreak havoc if not properly coordinated with existing in-country processes. While such initiatives may have very specific mandates and require special reporting, in many cases – and certainly in the case of Zambia – donors that are part of an established coordination process have demonstrated a strong willingness to accommodate such special needs in exchange for sincere efforts to work in a collaborative manner in support of a common strategy. It is nevertheless unfortunate that some of these special needs make it difficult for funds to be used to support health systems development. Without the systems in place, it is likely to be quite difficult to achieve some of the improvements in health indicators to which these initiatives aspire, let alone ensure that any gains are sustainable. This is a particular shortcoming of President Bush's Emergency Plan for AIDS Relief, and USAID should therefore advocate for the use of at least some funds to support the development of the systems that will help the Emergency Plan attain its ambitious goals.

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## **Annex 1**

### **Meetings Attended and Persons Met**

26 April 2004, Discussion of Benchmarks for Sector Budget Support, CPs represented: Denmark, EC, Ireland, Netherlands, Sweden, UK, USAID

28 April 2004, Monthly Coordination Meeting of the CPs

29 April 2004, Meeting of the Health Sector Committee

#### USAID/Zambia

Mr. Eustace Bobo, Chief Accountant

Ms. Amy Fawcett, Controller

Ms. Helen Gunther, Acting Mission Director

Ms. Barbara Winkler Hughes, Director, PHN Office, and SPA CTO

Dr. Dyness Kasungami, Senior Health Advisor (former District Health Manager, Kafue District, 1996-2002)

Mr. Chanda Musonda, Financial Analyst

Mr. Kifle Negash, Program Officer

#### Abt Associates Inc.

Mr. Brighton Bwacha, Deputy Chief of Party, ZIHPSYS

Mr. Yann Derriennic, Technical Advisor, Health Systems and Financing, Partnerships for Health Reform Plus (former Deputy Chief of Party, ZIHPSYS)

Dr. Cosmas Musumali, Chief of Party, ZIHPSYS

#### Ministry of Health

Mr. Davies Chifwembe, Director, Planning and Development

Mr. Nicholas Chikwenya, Donor/NGO Coordinator

#### Central Board of Health

Dr. Ben Chirwa, Director General

Ms. Lotta Karle, Planning Advisor

Mr. Roy Maswenyeho, Chief Accountant

Mr. Steve Mtonga, Financial Specialist

#### Provincial Health Office, Central Province

Dr. Wilma Meens, Senior Health Advisor

Ms. Mutinta Musonda, Human Resource Specialist

Mr. Liswani Tawila, Financial Specialist

District Health Management Team, Kabwe District

Ms. J.K. Miyoba, Manager for Planning and Development  
Ms. V.M. Mwape, Manager for Administration  
Mr. C. Siatuko, Personnel Officer  
Mr. J.K. Simgukwe, Accounting Officer  
Dr. D.M. Suyu, Director

Ministry of Finance

Ms. Agnes Musunga, Chief Economist, Bilateral Cooperation  
Mr. Bernard Phiri, USAID Desk Officer

CPs

Mr. Anthony Daly, Health Advisor, UK  
Dr. Marco Gerritsen, First Secretary for Health, Netherlands  
Mr. Toby Kasper, Zambia Portfolio Manager, GFATM  
Mr. Emilio Rossetti, Social Sectors Advisor, EC  
Ms. Margaret O'Callahan, Resident Representative, UNFPA

## Annex 2

### An Overview of Macroeconomic Performance

#### *Growth*

For the first time in over two decades, Zambian GDP has shown an upward trend for five consecutive years. Indeed, Table A1 shows that, with the exception of 1998, a modest level of growth has been registered since 1996 as the effects of liberalization have taken hold. Despite the recent upward trend, GDP growth has not kept pace with population growth, hence the huge decline in per capita income – more than 50 percent in real terms between 1970 and 2000 – and the increasing poverty incidence. If poverty is to be reduced, the rate of economic growth must exceed the rate of population growth.

**Table A1: Zambia – Selected Economic and Demographic Indicators**

Indicator	1997	1998	1999	2000	2001	2002	2003
GDP growth, real (annual %)	3.3	-1.9	2.2	3.6	4.9	3.3	4.3
GDP per capita, (current prices, US\$)	414	335	317	321	354	351	381
Current account balance and all grants (% of GDP)	-8.0	-10.9	-8.5	-13.5	-13.9	-9.4	-9.8
Exchange rate (kwacha/US dollar, end-of-period)	1415.0	2299.0	2632.0	4157.8	3830.4	4334.4	4700.0
Total debt service (% of exports of goods and services)	18.9	21.0	16.1	20.2	11.3	27.1	Na
Foreign direct investment (% of GDP)	5.3	6.1	5.2	3.8	2.0	5.3	1.2
Gross domestic investment (% of GDP)	14.6	16.4	17.6	18.7	20.0	17.5	20.0
Gross national savings (% of GDP)	3.7	-3.6	-6.6	2.9	4.6	-0.2	3.1
Weighted base lending rate (annual %)	37.2	37.4	42.6	37.6	46.7	42.5	39.6
Inflation, consumer prices (annual %)	24.8	24.0	27.0	26.0	18.7	26.7	17.2
Health budget (% of Dom. Discr. budget) out-turn	-	-	-	12.2	13.1	10.0	12.0
Overall fiscal deficit, incl. Grants (% of GDP)	-2.0	-5.2	-5.6	-5.9	-8.0	-5.6	-5.1
Aid (% of GNI)	16.5	11.5	21.0	25.8	10.1	18.1	Na
Formal sector employment	15.2	11.9	10.3	13.0	Na	Na	Na
Population growth (annual %)	2.5	2.3	2.2	2.1	Na	Na	Na

Sources: World Bank (2001); World Bank, 2003, "World Bank Country Assistance Strategy – Zambia;" World Bank, 2004, *World Development Indicators*; World Bank, various years, *SIMA and Region Database*; IMF, various years, *Government Finance Statistics*.

Long-term economic growth has been slowed by a variety of factors, *inter alia* copper dependence – i.e., lack of economic diversification – the secular decline in Zambia's terms of trade, the piecemeal and uneven character of reforms, lack of fiscal discipline, debt overhang, high transaction and transportation costs, and a regulatory environment that acts as a constraint to market forces.

## *Inflation*

Although inflation over the decade of the 1990s fell by over 75 percent, it remained at unacceptable levels (see Table A1). The high rate of inflation in Zambia is closely related to the high fiscal deficit. Indeed, directly following the introduction of cash budget system in January 1993, the inflation rate fell by over 70 percent. More recently, some encouraging signs emerged in 2001 with the rate of inflation falling below 20 percent.<sup>46</sup> The balance of payments pressures on the exchange rate, high growth of the money supply, occasional terms of trade shocks, and rising food prices as a result of the drought are some of the key factors that have contributed to the crippling level of inflation.

## *Deficit*

Zambia's fiscal policies under the Structural Adjustment Program have revolved around fiscal management that aims at balancing the budget by way of gradual reduction and eventual elimination of the large budget deficit, a goal that was achieved in 1996 and sustained in 1997 and 1998. Yet another fiscal policy measure that has long-term positive effects on the budget deficit is that of restructuring the public service to make it leaner, efficient, and productive. The budget deficits have generally been higher than targeted levels. For instance, compared with a projected deficit of 2 percent of GDP in 2003, the Government deficit stood at a 5.1 percent; in 2002, the deficit was 4.7 percent instead of 3 percent, as projected. It remains to be seen whether the projected 2 percent deficit for 2004 will be achieved against the enormous pressures on the budget.

## *Debt*

Another important consideration in any discussion of Zambia's economic prospects relates to the country's level of external indebtedness. By the mid-1980s, Zambia had become one of the most indebted countries in the world. The stock of Zambia's debt remains enormous, and debt service absorbs a significant share of resources meant for critical development programs. A highly indebted country like Zambia has difficulty obtaining access to private international capital markets for investments since its creditworthiness is compromised by its indebtedness. Zambia has been unable to service its debt from its own resources. Consequently, the country's debt is being serviced by cancellation and forgiveness, rescheduling, concessional borrowing, as well as grants.

Zambia reached the decision point under the IMF/World Bank HIPC Initiative in December 2000. It was expected to accede to the completion point by June 2003. However, on account of failure to fulfill certain quantitative and structural benchmarks, consideration of this matter was deferred to December 2003. Zambia is currently on the IMF's Staff Monitoring Program before being considered for restoration to the IMF's Poverty Reduction and Growth Facility in June

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<sup>46</sup> The reduction in inflation from 30.1 percent in 2000 to 17.5 in 2001 is explained principally by the Government's implementation of tight monetary policy and the maintenance of stability in the exchange rate, accompanied by prudent fiscal management. The higher than expected fiscal deficit did dampen prospects for an even greater decline in inflation during 2001. After a rise in 2002, inflation declined by year-end 2003 as fiscal restraint was exercised.

2004, which is a precondition for reaching the HIPC completion point. A write-off of approximately \$3.8 billion in debt is expected when Zambia reaches the completion point.

#### *Interest Rates*

Very high government borrowing from the domestic banking system and the Bank of Zambia's tight monetary policy led to an upward movement in Treasury bill rates, as well as lending and savings rates in 2001. Following adjustments in statutory reserves, and fiscal restraint on the part of the Government in terms of its call on the central bank and banking system, interest rates have declined steadily in 2004.

#### *Balance of Payments and Exchange Rates*

The deterioration in the balance of payments position has resulted in running down the country's foreign exchange reserves, a development that has had far-reaching consequences for the wider economy. Relative stability was registered, though, in the foreign exchange rates during the past year. The average central bank and commercial monthly average exchange rate declined precipitously in 2000, but measures by the government and the central bank helped stabilize the exchange rate and achieve some appreciation in 2001. Further measures by the central bank in 2002 and 2003 helped maintain stability in the foreign exchange market. The Government is now aiming to build up its foreign exchange reserves in 2004. While there have been ownership problems in the key export sector of mining, the resurgent price of copper on the international market provides strong assurances that the external sector will remain generally stable.

#### *Investment*

Zambia's weak economic performance has been accompanied by a major decline in national savings, whose levels of growth have continued to compromise the volume of investment that is so strategic for much sought after sustained capital formation, income generation, and employment creation. Table A1 shows that national savings have demonstrated a secular decline over the last decade, from a high of 16.6 percent in 1990 to less than 10 percent, and sometimes negative.

#### *Unemployment*

Since the intensification of the reform program, formal sector employment, particularly in the manufacturing sector, has not been favorable. The majority of the workforce has been pushed into the informal sector for subsistence. Informal sector employment has increased, while that of the formal sector has declined. The resultant decline in income levels for an average Zambian has sparked escalating poverty levels in a country currently classified as one of the poorest in the world. Today, Zambia is ranked at 165 out of 175 countries on the United Nations Human Development Index.

### **Annex 3**

#### **Chronology of Key Events**

*1991*

- January: National Health Policies and Strategies (NHPS) reviewed at national conference
- 31 October: Movement for Multiparty Democracy victorious in first multiparty election
- December: NHPS released

*1992*

- Health Policy Document adopted by Ministry of Health (MoH)
- NHPS approved by Cabinet

*1993*

- Health Reform Implementation Team created
- District Health Management Teams established
- District basket funding begun with pilot projects in three districts: Mansa (Luapula Province), Monze (Southern Province), and Senanga (Western Province)

*1994*

- Health Sector Support Policy launched
- National Health Strategic Plan (NHSP) for 1995-98 developed
- District Health Boards established
- Financial and Administrative Management System and Health Management Information System created

*1995*

- National Health Services Act passed

*1996*

- Central Board of Health (CBoH) created, with four regional offices replacing nine provincial offices
- National AIDS Prevention and Control Program established

*1999*

- CBoH reorganized, with nine provincial offices replacing four regional offices
- 9 March: Sector Program Assistance (SPA) Agreement signed by USAID and the Government of Zambia
- 24 November: Memorandum of Understanding between the Government and Cooperating Partners signed

*2000*

- Poverty Reduction Strategy Paper (PRSP) developed
- New NHSP for 2001-05 developed
- National HIV/AIDS Council and Secretariat established
- National HIV/AIDS/STDs/STI/TB Strategic Plan developed
- January-March: Joint Identification and Formulation Mission undertaken
- December: Heavily Indebted Poor Countries Initiative decision point reached

*2002*

- May: PRSP endorsed by IMF and World Bank

*2003*

- Medium-Term Expenditure Framework for 2004-06 introduced
- National Decentralization Policy approved by Cabinet



- Mid-Term Review of NHSP undertaken
- 3 June: Amended and Restated SPA Agreement signed

*2004*

- April: Mid-Term Review of NHSP completed
- 30 September: SPA Agreement due to expire

## Annex 4

### Performance Milestones for the Most Recent Tranche of SPA Funding

#### Performance Area: Basic Health Care Package Funding

*Performance Milestone 5.3.1 (\$300,000):* Submit evidence to USAID, in form and substance satisfactory to USAID, that GRZ budget releases to the Ministry of Health have been at least 13 percent of total GRZ actual domestically financed discretionary expenditure in the applicable GRZ fiscal year. Domestically financed discretionary expenditure is defined as total expenditure, less non-discretionary expenditures as defined in the GRZ budget for the applicable fiscal year.

*Performance Milestone 5.3.2 (\$300,000):* Submit evidence to USAID, in form and substance satisfactory to USAID, that the Ministry of Finance and National Planning (MoFNP) has disbursed to the Ministry of Health (MoH) and that MoH has disbursed to the Central Board of Health (CBoH) the Kwacha generated through the sale of US dollars provided through this program in the previous funding tranche as supplemental funding, as defined in section 3.2 (c). The supplemental funding will be in addition to the “usual disbursements” of the MoH budget to the CBoH’s district basket. “Usual disbursement” is defined as the average proportion of the MoH budget disbursed to the CBoH district basket in the years 1997-99, excluding personnel emoluments, donor inflows, and drugs. The district basket funds are to be used by the District Health Boards to deliver basic health care for their populations.

**Table A2: Establishing “Usual Disbursements” – Baseline Data (Kwacha)**

<b>Year</b>	<b>GRZ Actual Expenditure (MoH)<sup>47</sup></b>	<b>District Basket Transfers<sup>48</sup></b>	<b>Percent</b>
1997	53,736,084,647	7,009,931,000	13.0
1998	31,862,571,742	6,196,500,000	19.4
1999	40,254,553,085	5,138,910,566	12.8
<b>Avg.</b>	<b>41,951,069,825</b>	<b>6,115,113,855</b>	<b>15.1</b>

Submit evidence to USAID, in form and substance satisfactory to USAID, that MoFNP has disbursed to the USAID Trust Fund the Kwacha generated through the sale of US dollars provided through the program in the previous funding tranche, as defined in section 3.2 (c).

#### Performance Area: People-Level Impact

*Performance Milestone 5.5.1 (\$1,000,000):* Submit evidence to USAID, in form and substance satisfactory to USAID, that at least 8 percent of District Health Boards (six – half of those which set targets for 2000) reported improvements in access and utilization

<sup>47</sup> These are net amounts, excluding expenditures on personnel emoluments, donor inflows, and drugs.

<sup>48</sup> Sources for these data include CBoH financial statements from the district basket steering committee reports and CBoH accounts.

at the end of 2000; and at least 67 percent of the District Health Boards (48) established performance targets in their annual contracts for 2001 which can be monitored through the Health Monitoring Information System and the Financial and Administrative Management System. The performance targets relate to access, quality, and utilization.

Performance Area: Financial Reporting, Accountability, and Management

*Performance Milestone 5.6.1 (\$300,000):* Submit evidence to USAID, in form and substance satisfactory to USAID, that the Central Board of Health (CBoH) has issued a comprehensive annual financial report which includes financial statements meeting standards for accountability and which is independently certified by the GRZ Auditor-General and/or a private sector audit firm as presented in conformity with generally accepted accounting principles, international accounting standards, or another comprehensive basis of accounting satisfactory to USAID.

Submit evidence to USAID, in form and substance satisfactory to USAID, that CBoH has issued a comprehensive annual report of its activities. The annual report should contain in an annex a report on the executed activities compared with planned activities (effectiveness of CBoH) and the reports of the Health Sector Steering Committee, which contain data on resources and indicators of performance (efficiency of CBoH).

Both of these reports should be finalized within 10 months of the end of the applicable GRZ fiscal year.

*Performance Milestone 5.6.2 (\$100,000):* The grantee shall provide evidence that it has complied with section 7.1 by (i) maintaining a system of books, records, and underlying documentation adequate to assume compliance with this Agreement and (ii) establishing auditing standards for such books and records.